PRIORITY MEDICAL ASSOCIATES

*****PLEASE COMPLETE IF DUE TO A MOTOR VEHICLE ACCIDENTOR OTHER INJURY*****

Date of Accident: _____ Hour: _____ □AM □PM

If auto accident, were you □ DRIVER? □ PASSENGER? □ PEDESTRIAN?

If you were the DRIVER, please name any passengers: _____

Brief Description of Accident: _____

_____

_____

Please make a check in the box below to indicate if you are experiencing ay of the following symptoms:

Headache	
Pressure in Head	
Neck Pain	
Vomiting	
Dizziness	
Blurred Vision	
Balance Problems	
Light Sensitivity	
Sound Sensitivity	
Feeling Slowed Down	
Feeling like in a “Fog”	
Don’t Feel Right	
Difficulty Concentrating	

Difficulty Remembering	
Fatigue or Low Energy	
Confusion	
Drowsiness	
Trouble Falling Asleep	
More Emotional	
Irritable	
Sad	
Nervous or Anxious	
Don’t Feel Normal	
Other (Write in)	
Other (Write in)	

Did you treat with a Doctor or Hospital? Yes No

If YES, name of doctor or hospital: _____